VISION LOSS REHABILITATION™
CANADA

Community/Self-Referral Form

Thank you for choosing Vision Loss Rehabilitation Canada. Whether you're making a referral for yourself, a client, or someone you care about, we're here to offer support.

We encourage you to complete all fields on this form so we can build the best possible rehabilitation plan.

Please send this completed form by fax to 1-844-268-7294. *Indicates all required fields.

Person's Information	
*Date of Referral	
Person's Health Card #	
*Person's Legal Name	
*Person's address 1	
Person's address 2	
*Person's City	
*Person's province	
*Person's Postal Code	
*Person's Telephone # (Daytime or Cell)	
*Person's Date of birth (YYYY-MM-DD)	

1 *How does the person's vision loss impact their quality of life?

- ☐ Safety
- ☐ Daily Living
- ☐ Job/Academic
- ☐ Other Reason for the Referral:

2 *Have they had a visit with their eye doctor in the last year?

- ☐ Yes
- ☐ No

Diagnosis:

Eye Doctor's Name:

3 *Is the person currently in a hospital or rehabilitation facility?

☐ Yes ☐ No

4 If yes, is this referral part of the discharge plan?

☐ Yes ☐ No

5 Is there additional assessment information to accompany this referral?

☐ Rai HC/CHA ☐ No

☐ Health Care Assessment ☐ Other:

6 *Person's preferred language:

☐ English ☐ Other (Please specify):

☐ French ☐ Consent

7 *Has the person been made aware of this referral and provided their consent?

☐ No ☐ Yes

Date consent was given (DD/MM/YY):

If consent was provided by someone other than the person being referred:

Alternate contact name: Relationship:

Daytime contact number:

Referral Agency Information

*Referral Completed by:

☐ Agency/Worker

☐ Self-Referral

☐ Family Referral

*Name of Person Making Referral:

*Organization/Relationship:

Phone #:

*VLRC office closest to patient (insert all same office options that exist on the existing Physician's Referral Form)

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